



CANNON BUILDING  
861 SILVER LAKE BLVD., SUITE 203  
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE  
**BOARD OF DENTISTRY AND DENTAL HYGIENE**

TELEPHONE: (302) 744-4500  
FAX: (302) 739-2711  
WEBSITE: [DPR.DELAWARE.GOV](http://DPR.DELAWARE.GOV)  
EMAIL: [customerservice.dpr@state.de.us](mailto:customerservice.dpr@state.de.us)

## **APPLICATION FOR DENTIST LICENSURE INSTRUCTION SHEET**

### **When to File**

File this application for Delaware Dentist licensure if you are not contracted to practice at a Federally Qualified Health Center (FQHC) in Delaware. If you have an FQHC contract, file the [Application for Dentist-FQHC Provisional Licensure](#).

### **Information about Required Examinations**

All applicants for Dentist licensure, *regardless of years in practice*, are required to pass the Delaware Practical Board Examination in dentistry and the Delaware Jurisprudence Examination.

- The [Practical Board Examination](#) is offered twice a year, at the beginning of January and June. The deadlines for applications to sit for the exams are December 1 for the January exam and May 1 for the June exam. The exam is limited to 18 candidates on each date. It is important to submit your application before the deadline for the exam you want to take.
- The [Delaware Jurisprudence Examination for Dentists](#) is an “open-book” test with 30 multiple-choice questions. It is based on the [Delaware Code](#) and the Board’s [Rules and Regulations](#).

### **Requirements for All Applications**

You must submit the documentation in this section in order to be approved to sit for the practical examination. Additional documentation listed in the next section is required to be considered for licensure when you have passed the exam.

- ☐ Submit a completed, signed and notarized [Application for Dentist Licensure](#) by the exam deadline.
- ☐ Enclose payment for the non-refundable fees by check or money order made payable to “State of Delaware.” You may combine the fees in one payment:
  - ☐ [processing fee](#)
  - ☐ [examination fee](#) – If you fail to sit for the examination in the month you select on the application, you will forfeit this fee. You cannot transfer it to the next examination date.
- ☐ If you choose to submit your non-refundable examination fee after the deadline for the exam you want to take (May 1 for the June exam or December 1 for the January exam), enclose the non-refundable [Late Exam fee](#). This fee is in addition to the processing fee and examination fee.
  - **You will be admitted to the exam only if a seat is still available.**
  - If no seat is available, **you will forfeit both the examination fee and late fee that you paid.** To register for the next exam date you must pay the examination fee again. You cannot transfer it to a later examination date.
- ☐ Enclose a copy of your current cardiopulmonary resuscitation (CPR) certification card.
  - The Board office must receive this document by the exam deadline.
- ☐ Arrange for the Board office to receive an official transcript from Board-recognized undergraduate college or university, sent directly from the school to the Board office. The transcript must show that you completed at least two years of undergraduate study in an accredited college or university.
  - The Board office must receive this document directly from the school by the exam deadline.

- ☐ Arrange for the Board office to receive an official transcript from your dental college or university, sent *directly* from the school to the Board office. The transcript must show your degree and date of graduation.
  - The dental college/university must be accredited by the Commission on Dental Accreditation of the American Dental Association (CODA)
  - The Board office must receive this document directly from the school by the exam deadline.

When the deadline for the exam date passes, the Board office will mail examination packets to all candidates who applied on time and whose documentation it has received. Candidates who apply late will receive their examination packets only after the Board office confirms availability of a seat and receives all required documentation.

## Requirements *After* the Practical Examination

*You must submit the additional documentation listed below in order to be considered for licensure when you've passed the practical examination.* However, you may submit the documents at any time, before or after taking the exam. When you have passed the practical exam and all required documentation listed below has been received, the credentialing committee will review your application. If approved, your license will be issued.

- ☐ Arrange for the Board office to receive **one** of the following:
  - Proof (such as a letter from the sponsoring institution) that you have one year of experience as a dental intern in a CODA-accredited general practice residency sent directly from the sponsoring institution to the Board office
  - Tax form W-2s or other proof that you have practiced actively for three years in another jurisdiction (state, U.S. territory or District of Columbia)
  - Proof (such as a letter from the sponsoring institution) that you have completed four or more years in a CODA-approved specialty residency, sent *directly* from the sponsoring institution to the Board office

If you have been in a CODA-approved specialty residency *of less than four years*, submit proof (such as a letter from the sponsoring institution) that the program you're in:

- meets the goals, objectives, proficiencies and competencies set forth in Standard 2.4 of the CODA *Accreditation Standards for Advanced Education Programs in General Practice Residency*, ©2007 (Section 4.3 of the Board's [Rules and Regulations](#), and
- includes a rotation of at least 70 hours in anesthesia and a rotation of at least 70 hours in medicine.

- ☐ Arrange for the Board office to receive your National Board Examination score report, sent *directly* from the Joint Commission on National Dental Examinations to the Board office. See [Score Report Request](#).
- ☐ Arrange for the Board office to receive license verification letters from *each* jurisdiction (state, U.S. territory or District of Columbia) where you are now, or have ever been, licensed, sent *directly* from the jurisdiction to the Board office.
- ☐ If you have ever been licensed in another jurisdiction, request a self-query from the [National Practitioner Data Bank](#). When you receive the report, send the original to the Board office.
- ☐ Submit your completed, signed and notarized [Jurisprudence Examination for Dentist Candidates](#).
- ☐ Complete the *Criminal History Record Check Authorization* form to request State of Delaware and Federal Bureau of Investigation criminal background checks. Follow the instructions on the authorization form to arrange to be fingerprinted.
- ☐ If you have never been issued a U.S. Social Security Number (SSN), submit a [Request for Exemption from Social Security Number Requirement](#).

The Privacy Act of 1974, Section 7, requires the following information to be given to all applicants: Applicants for any Delaware professional or occupational license, permit, registration or certificate (other than Gaming permits) are required to provide a U.S. SSN (29 Del. C. §8735(m)). The Division of Professional Regulation uses the SSN primarily to verify identity and safeguard personal information. It may also be used to enforce child support obligation (13 Del. C. §2216) and for other lawful purposes.



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## APPLICATION FOR DENTIST LICENSURE

### TYPE OF APPLICATION

1. Check the month when you wish to sit for the examinations:

- ☐ January – I understand that I must submit this application, the processing and examination fees, and copy of my CPR card and that the Board office must receive my transcripts no later than the deadline of December 1.
- ☐ June – I understand that I must submit this application, the processing and examination fees, and copy of my CPR card and that the Board office must receive my transcripts no later than the deadline of May 1.

**The examination fee you submit with this application is non-refundable and non-transferable. If you do not sit for the exams in the chosen month, you will forfeit the fee.**

### IDENTIFYING AND CONTACT INFORMATION

2. Name: \_\_\_\_\_  
Last/Family Name First Middle Maiden
3. Other Name(s) Used: \_\_\_\_\_ ☐ None
4. Have you ever sought or been granted a dental license under another name? Yes ☐ No ☐ If yes, enter name and state where you used the name: \_\_\_\_\_
5. Date of Birth (month/day/year): \_\_\_\_\_ Gender: Male ☐ Female ☐
6. Have you been issued a U.S. Social Security Number? Yes ☐ No ☐ If yes, enter your SSN: \_\_\_\_\_  
If no, you must file a [Request for Exemption from Social Security Number Requirement](#).
7. Mailing Address: \_\_\_\_\_  
City State Zip
8. Phone: \_\_\_\_\_ Email: \_\_\_\_\_ ☐ None  
Daytime Home

### EDUCATION AND RESIDENCY

9. Enter the following information about your pre-professional education:

University/College: \_\_\_\_\_ Major: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Degree: \_\_\_\_\_  
Dates Attended: From: \_\_\_\_\_ To: \_\_\_\_\_ Graduation Date: \_\_\_\_\_  
month/day/year month/day/year month/day/year

**Arrange for the Board office to receive an official transcript, sent *directly* from the college/university to the Board office, before the exam deadline.**

10. Enter the following information about your Dental education:

Dental School Name: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Degree: \_\_\_\_\_

Dates Attended: From: \_\_\_\_\_ To: \_\_\_\_\_ Graduation Date: \_\_\_\_\_  
month/day/year month/day/year month/day/year

**Arrange for the Board office to receive an official transcript, sent *directly* from your dental school to the Board office.**

11. Are you currently in **or** have you already completed a CODA-approved residency program? Yes ☐ No ☐ If no, skip to Question 12. If yes, complete the following information about your residency program, then skip to the **LICENSURE HISTORY** section.

Name of Sponsoring Institution: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

\_\_\_\_\_  
City State Zip

Start Date (month/year): \_\_\_\_\_ End Date (month/year): \_\_\_\_\_

Type of Residency: ☐ General Practice

**Arrange for the Board office to receive proof (such as a letter from the sponsoring institution) that you have one year of experience as a dental intern in this residency sent directly from the sponsoring institution to the Board office.**

☐ Specialty – Identify specialty: \_\_\_\_\_

- If you have completed your residency, arrange for the Board office to receive proof (such as a letter from the sponsoring institution) that you have completed the residency sent directly from the sponsoring institution to the Board office.
- If you have not yet completed your residency, arrange for the Board office to receive proof (such as a letter from the sponsoring institution) that the program you're in meets the requirements explained on the Instruction Sheet.

12. Do you have three years of active dental practice? Yes ☐ No ☐ If yes, complete the following table to document the three years of practice.

EMPLOYER NAME	CITY	STATE	DATES (month/day/year)	
			From	To

**Enclose Tax form W-2s documenting the periods listed above.**

## LICENSURE HISTORY

13. Enter the following information about your National Board Examinations:

Year Taken: \_\_\_\_\_ Part I Score: \_\_\_\_\_ Part II Score: \_\_\_\_\_

- **Arrange for the Board office to receive your National Board Examination score report, sent *directly* from the Joint Commission on National Dental Examinations to the Board office.**
- **In addition to passing the Delaware Practical Board Examination, you must also submit your completed, signed and notarized [Jurisprudence Examination for Dentist Candidates](#).**

14. Have you ever been denied a license? Yes ☐ No ☐ If yes, enter: Year Denied: \_\_\_\_\_ State: \_\_\_\_\_

Explain why the license was denied: \_\_\_\_\_

15. Are you (*or have you ever been*) licensed in any other jurisdiction? Yes ☐ No ☐ If yes, enter the following information about *each* license:

JURISDICTION	LICENSE NUMBER	ISSUE DATE	EXPIRATION DATE	STATUS (e.g.,active)

Arrange for *each* jurisdiction listed to send a verification of licensure *directly* to the Board office. Also, request a self-query from the [National Practitioner Data Bank](#). When you receive the report, send the original to the Board office.

## DISCLOSURES

16. Have you engaged in the illegal use of controlled dangerous substances within that past two years? Yes ☐ No ☐ **If yes, continue to Question 17. If no, skip to Question 18.**

17. Are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you in order to assure that you are not illegally using controlled substances? Yes ☐ No ☐ **If yes, explain fully:**

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18. Have you ever been denied a DEA (Narcotic) registration number? Yes ☐ No ☐ Current DEA # \_\_\_\_\_  
**If yes, submit a signed statement explaining fully.**

19. Has your professional license ever been subjected to disciplinary action (including but not limited to consent agreements, fines, probation, suspension or revocation)? Yes ☐ No ☐ **If yes, submit a signed statement explaining fully. Include an official Board order or other documents.**

20. Has any malpractice action been brought against you in the past five years? Yes ☐ No ☐ **If yes, enclose a list on a separate sheet of paper. Include dates, disposition and amount of awards or settlements, if any.**

21. Are any disciplinary or ethical complaints currently pending against you? Yes ☐ No ☐ **If yes, submit a signed statement fully explaining. Include copies of all official documents or Board orders.**

22. Are you physically or mentally incapable of engaging in the practice of dentistry according to generally accepted standards? Yes ☐ No ☐ **If yes, continue with Question 23. If no, skip to the DUTY TO REPORT section.**

23. Do you agree to submit to an examination to determine such capability as the Board may deem necessary?  
Yes ☐ No ☐

**Complete the *Criminal History Record Check Authorization* form to request State of Delaware and Federal Bureau of Investigation criminal background checks. Follow the instructions on the authorization form to arrange to be fingerprinted.**

## DUTY TO REPORT

24. To obtain a license in Delaware, you must certify that you understand that you have a **mandatory** obligation to self report any of the following within 30 days:

- Any arrest or the bringing of an indictment or information charging you with a crime substantially related to the practice of dentistry and dental hygiene as defined in Section 11.0 of the Board's Rules and Regulations.
- Any conviction, including any verdict of guilty or plea of guilty or no contest, of any crime substantially related to the practice of dentistry and dental hygiene as defined in the Section 11.0 of the Board's Rules and Regulations.

I certify that I have read and understand all provisions in the Delaware Dental Practice Act, including [24 Del. C. §1131](#) and the [Rules and Regulations](#) listed above, and that I understand my *duty to self report*. Yes ☐ No ☐

25. To obtain a license in Delaware, you must certify that you understand that you have a **mandatory** obligation to make an immediate oral report to the to the Department of Services for Children, Youth and Their Families if you know of, or you suspect, child abuse or neglect under Chapter 9 of Title 16 and to follow up with any requested written reports.

I certify that I have read and understand [16 Del. C. §903](#) and that I understand my *duty to report*. Yes ☐ No ☐

26. You have a **mandatory** duty to file a written report with the Division of Professional Regulation within 30 days if you reasonably believe that any other dental or dental hygiene practitioner **or** any other healthcare practitioner, including any person licensed to practice medicine in Delaware:

- has engaged in or is engaging in conduct that would constitute grounds for disciplinary action
- may be unable to practice with reasonable skill and safety to the public due to mental illness or mental incompetence, physical illness (including deterioration through the aging process or loss of motor skill), or excessive abuse of drugs (including alcohol)
- is excessively using or abusing drugs including alcohol.

I certify that I have read and understand the provisions of [24 Del. C. §1131A](#) and that I understand my *duty to report*. Yes ☐ No ☐

**To ensure consideration of your license application at the next Board meeting, the Board office must receive all of these items no later than 4:30 PM ten full working days before the Board's meeting date:**

- Completed, signed and notarized application form
- Fee payment
- All required supporting documentation.

**Applications that are not complete within 12 months of filing may be considered abandoned and discarded. When your application is complete, please allow 4-6 weeks to receive your license.**

## AFFIDAVIT

I hereby apply to be considered for licensing as a Dentist by the Board of Dentistry and Dental Hygiene under the standards, qualifications and procedures established under Title 24, Chapter 11, of the *Delaware Code*. I have read the State statute governing dentists in Delaware. I have also received and read the Board's Rules and Regulations regarding the practice of Dentistry in Delaware. I understand that the Board may require evidence additional to the material herein, including a written examination, and transcripts of academic training.

I hereby swear or affirm that the information contained in this application is correct and I understand that any intentionally fraudulent information will be reported to the Attorney General.

**Applicant Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

County of \_\_\_\_\_ State of \_\_\_\_\_

Sworn or affirmed before me a Notary Public this \_\_\_\_\_ day of \_\_\_\_\_, 2\_\_\_\_\_.

Notary Signature: \_\_\_\_\_

SEAL

My commission expires on \_\_\_\_\_

**APPLICATIONS THAT ARE UNSIGNED, NOT NOTARIZED, INCOMPLETE OR SUBMITTED WITHOUT THE REQUIRED FEE WILL BE REJECTED.**

# Instructions for Requesting a Criminal Background Check

**Both State of Delaware and Federal Bureau of Investigation criminal background checks are required.**

## Applicant Notification

Your fingerprints will be used to check the criminal history records of the Federal Bureau of Investigation (FBI). You have the opportunity to challenge the accuracy of the information contained in the FBI identification record. See [Title 28, CFR 16.34](#) for the procedure to obtain a change, correction or update in the FBI record.

## Locations

### **Kent County – Primary Facility**

State Bureau of Identification  
Blue Hen Mall & Corporate Center  
655 S. Bay Rd. Suite 1B  
Dover, DE 19901

**Walk-ins accepted:** Mon 8:30 am – 6:30 pm, Tue - Fri 8:30 am – 3:30 pm  
Customer Service: (302) 739-2134

### **New Castle County - Satellite Facility**

State Police Troop Two  
100 LaGrange Ave  
Newark, DE 19702  
(between Rts. 72 and 896 on Rt. 40)

**By appointment only**  
Scheduling: (302) 739-2528 (local)  
(800) 464-4357 (toll free)

### **Sussex County – Satellite Facility**

Thurman Adams State Service Center  
546 S. Bedford Street, Rm. 202  
Georgetown DE 19947  
(across from DelDOT & Troop 4)

**By appointment only**  
Scheduling: (302) 739-2528 (local)  
(800) 464-4357 (toll free)

## Applicants in Delaware

1. If you are using the New Castle County or Sussex County locations, call **(800) 464-HELP (4357)** to schedule an appointment. No appointments are needed at the Kent County location.
2. Take the completed *Authorization for Release of Information* form to one of the offices listed above with the fee of \$65.00, to cover both the State of Delaware and Federal Bureau of Investigation criminal checks. Money orders and credit cards other than American Express are accepted at all locations. New Castle and Kent Counties accept cash; Sussex County does not accept cash. **Personal checks are not accepted in any county.** As fees are subject to change, contact the agency where you plan to submit your forms for current fees.

## Applicants Not in Delaware (including Out-of-State or Outside the United States)

1. Your local police agency can fingerprint you. All types of fingerprint cards are accepted. Or, you may print a [FD-258 fingerprint form](#) available on the FBI website at [www.fbi.gov](http://www.fbi.gov) – click *Services*, then *Identity History Summary Checks*, then scroll down to Option 1, Step 2, and click the link for *standard fingerprint form (FD-258)*. You may print the form on regular paper.
2. Your *Authorization for Release of Information* form and the fingerprint card must be complete. If identifying information is missing (such as name, date of birth, race, gender, etc.), your form will be returned.
3. **Mail** the *Authorization* form, fingerprint card, and *certified* check or money order (**personal checks are not accepted**) for \$65.00 made payable to “Delaware State Police” to:

**Delaware State Police  
State Bureau of Identification (SBI)  
PO Box 430  
Dover, DE 19903-0430**

**DO NOT SEND THIS FORM OR FEE TO YOUR PROFESSION'S BOARD OFFICE.**  
**DO NOT SEND THIS FORM OR FEE TO THE DIVISION OF PROFESSIONAL REGULATION.**  
**⇒ ALLOW FOUR WEEKS FOR RECEIPT OF RESULTS.**



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**AUTHORIZATION FOR RELEASE OF INFORMATION**  
**CRIMINAL HISTORY RECORD CHECK FOR PROFESSIONAL LICENSURE APPLICANTS**

*Please print or type all information in black ink.*

**Check the type of license for which you are applying:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Adult Entertainment   | <input type="checkbox"/> Mental Health (LPCMH, LCDP, LMFT, LAPCMH, LAMFT)                              | <input type="checkbox"/> Physical Therapy/Athletic Trainer                             |
| <input type="checkbox"/> Charitable Gaming Vendor  | <input type="checkbox"/> Nursing (RN, LPN, APRN)   | <input type="checkbox"/> Podiatry  |
| <input type="checkbox"/> Chiropractic  | <input type="checkbox"/> Nursing Home Administrator  | <input type="checkbox"/> Psychology  |
| <input type="checkbox"/> Dental  | <input type="checkbox"/> Occupational Therapy  | <input type="checkbox"/> Real Estate Appraiser (includes Appraisal Management Company) |
| <input type="checkbox"/> Funeral   | <input type="checkbox"/> Optometry   | <input type="checkbox"/> Speech/Hearing  |
| <input type="checkbox"/> Massage   | <input type="checkbox"/> Pharmacy (includes key personnel of facilities licensed by Board of Pharmacy) | <input type="checkbox"/> Social Work   |
| <input type="checkbox"/> Medical (Physicians, Physician Assistants, Respiratory Care Practitioners, Eastern Medicine Practitioners, Acupuncture Practitioners, Genetic Counselors, Polysomnographers, Midwifery Practitioners (CM, CPM)) |  | <input type="checkbox"/> Texas Hold'em Individual                                      |

**Print your current full name:**

\_\_\_\_\_  
Last Name First Name Middle Initial Suffix (e.g., Jr., Sr.)

**Enter all other names you have used in the past (including, but not limited to, maiden name, former married names, alternative spellings):**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

As an applicant, I authorize release of any and all information that you have concerning my **CRIMINAL HISTORY RECORD INFORMATION**. I hereby release you, your organization, the State of Delaware and others from any liability or damage which may result from furnishing this information:

**SIGNATURE OF PERSON PRINTED:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Phone: Home \_\_\_\_\_ Work \_\_\_\_\_

**Mail the results of my criminal history request to:**

**Division of Professional Regulation  
861 Silver Lake Boulevard, Suite 203  
Dover DE 19904  
SLC D420A**

**USE OF CRIMINAL HISTORY RECORD INFORMATION IS RESTRICTED BY LAW AND SHALL BE LIMITED TO THE PURPOSE FOR WHICH IT WAS GIVEN. MISUSE CONSTITUTES A CRIMINAL VIOLATION.**